

**Finance Working Group Report:
Physicians and Physician Practice Issues**

In this report, the Finance Working Group outlines several concerns presented by leaders of Massachusetts physicians relating to their practices and the adequacy of public and private payments. We also discussed the roles physicians could play in creating a more cost effective Massachusetts health care system. In addition, the report provides additional data prepared for the Working Group that relates to other relevant issues.

At the outset, the Finance Group recognizes that economic conditions have changed considerably over the last several months and critically over the last several weeks. The fiscal environment in which health policy choices must be made has become highly constrained. Under better conditions, decisions regarding the allocation of limited resources can be made with some degree of discretion. Unfortunately, choices are now very limited. In the weeks and months ahead, the Commonwealth will be best served if we can at least maintain the essential programs. The Finance Group believes that in this instance, with regard to physicians and Medicaid, the essential is to maintain broad eligibility and to continue emphasizing primary care.

As particular recommendations are suggested, the Finance Group suggests that they be evaluated in light of the extent to which they further the Medicaid and/or broader state health policy goals outlined in our report to you last month:

- **Fair Payment:** Medicaid payment for a particular service should cover a reasonable percentage of the necessary cost of efficiently delivering that service.
- **Medicaid Access Preservation:** The state's Medicaid policy should work to ensure reasonable access to services for and by Medicaid enrollees.
- **System Stability:** The state should work to preserve and stabilize the health care delivery system in this time of financial difficulty, preserving those services that are necessary to protect the health of all Massachusetts residents.

In addition, the Finance Group recognizes and emphasizes that physicians are in a unique position to determine how resources are used in our health care system.

General Concerns

Deteriorating Practice Conditions

The physicians and their consultants who met with the Finance Group expressed concern that the quality of professional life for physicians in Massachusetts has deteriorated over the last several years and that, as a result, Massachusetts is having difficulty attracting

and retaining physicians. The deterioration is manifested in several different ways, relating primarily to changes in the nature of medical practices and to lack of adequate payment.

Physicians have told us that the patient-physician relationship has changed as patients have become more demanding on physicians' time – in asking about specific medications or treatments, and in expecting prompt return of telephone calls and quick appointment availability. Physicians are evaluated, by health plans and by consumers, by how long it takes them to return a phone call and by how long patients must wait until the first available appointment. At the same time, responding quickly has become more difficult as physicians need to spend more time researching the latest technology and treatments and more time managing care for increasing numbers of patients with multiple chronic conditions.

Despite the increasing proportion of physicians' time that must be spent on administrative tasks, returning phone calls, research and patient management, most payment systems still rely on the number of patient encounters as the method for determining a physician's productivity and/or payment.

Over the past decade, physicians in Massachusetts and across the country have migrated out of solo, dual, and small group practices to larger multi-specialty groups, many of which are owned by organized systems of care, such as CareGroup and Partners HealthCare. [See figures 1-2] Reasons for that migration included the promise of efficiency and economies of scale in administrative matters and overhead, as well as increased bargaining power in an era of expanding managed care. The concerns voiced to the Finance Group suggest that these benefits have not been realized in a way that has made physicians' professional lives sufficiently simpler or more rewarding than they were in solo or small group practice.

At the same time that these changes in practice environments have occurred, for the large physician groups associated with teaching hospitals, the ability to cross-subsidize teaching, training, and biomedical research through patient care dollars has been reduced or eliminated. In addition the payment rates from Medicare, Medicaid and private payers have failed to increase as rapidly as practice costs. Given the physicians' critical role in deciding which resources are to be used in patient care, attempts to align economic incentives with clinical decisions through capitation, withholds and other forms of incentive payments were broadly tested in the recent past and largely rejected. It appears that Massachusetts physicians are now mostly paid through fee-for-service systems.

Many of the problems outlined above are not unique to Massachusetts. They may have a more pronounced effect in Massachusetts, however, due to the relatively high percentage of people covered by managed care plans here. Moreover, physician income in Massachusetts has been and continues to be lower than in many other parts of the country. [See figure 3] Anecdotal evidence abounds for the proposition that physicians in private practices are working harder and harder to support the same level of income. Thus, the physician community believes that the combined effect of the changes in the

practice of medicine and lower relative incomes has made the practice of medicine in Massachusetts less rewarding and recruitment more difficult.¹ Massachusetts is therefore at risk of losing critical physician resources.

Massachusetts Continues to Have High Numbers of Exceptionally Well-Trained Physicians.

The Finance Group acknowledges that Massachusetts has enjoyed extraordinary resources in health care, including a number of the nations' best doctors and hospitals. But it is also true that physicians' income in Massachusetts has been lower than that of their counterparts in other regions for many years. That fact has not deterred physicians from living and practicing here. Even accepting the credible claims that recruitment and retention of physicians is becoming more difficult, it does not appear that there is any imminent shortage of physicians in Massachusetts, nor are there widely reported problems in accessing physician services (with possible exceptions in certain specialty areas and/or certain geographic areas).

The distribution of the physicians geographically generally tracks the distribution of the population with some significant over weighting of physicians within the 495 beltway. [See figure 4 map] For a number of reasons, including the Commonwealth's richness of academic medical centers, sponsored biomedical research, and life style considerations, approximately 70% of physicians in metropolitan Boston trained here and have stayed here.² Despite the stated problems of income, practice and professional lifestyle, the number of physicians licensed and practicing in Massachusetts per 100,000 population is high, at 454, 59% above the national average of 285, and significantly higher than other states including New York, Connecticut and Maryland. [See figure 5]

Even though we have a high number of physicians per capita, the physicians who spoke to the Finance Group feel that there may not be enough physicians on the front line of medical practice to meet the demand for services. The reported high number of practicing physicians, the high percentage of locally trained physicians and very high number of specialists and sub-specialists may not accurately reflect either physician availability or access to primary care. They believe that current survey results do not capture the actual nature of practice or the division of time among patient care, teaching, training and biomedical research. For example, it is well understood that a number of specialists function as primary care physicians for many of their patients. It is not uncommon for a cardiologist, for example, to be the coordinating physician (a.k.a. primary care physician) for those patients with congestive heart failure. In addition, the fact that many physicians spend portions of their time in teaching and research may mean that the ratio of physicians to population will not accurately reflect the number of clinical hours that are available for patient care (although the fact that our many interns and residents provide large amounts of direct care may counteract this effect, to some extent).

¹ The MMS Physician Practice Environment Index Report- Massachusetts Medical Society. July, 2001. There is also anecdotal support for the proposition that those physicians who sold their practices to integrated delivery systems work less hard than they did in private practice.

² St. Louis Health Care: A Regional Comparison. Vol. III. St. Louis Area Business Health Coalition. August 2001.

Findings

Despite these challenges in interpreting the data, the Finance Working Group finds that the overall supply of physicians is adequate, and that most specialists and sub-specialists are in excess supply. [See figures 6-7] Although the Finance Group has not reviewed data on specific specialties, there is anecdotal support for the proposition that in some specialties, in some geographic areas, there are un-met needs including anesthesia, radiology, dermatology, and child and adolescent psychiatry.

Although there is not a general shortage of physicians, there is concern that the Commonwealth is at risk of losing its preeminence in the medical field and many of our top institutions may already be unable to recruit their top candidates to important positions. While the Finance Working Group accepts that these risks are real, we also note that current data do not suggest that physicians are leaving Massachusetts in large numbers. Nonetheless, we think it is important for the Commonwealth to do what it can to improve the economic and practice environment for physicians.

As we have pointed out in other reports to this body on other components of Massachusetts health care system, the Commonwealth's arsenal for direct intervention is somewhat limited. It includes:

- Direct reimbursement through Medicaid
- Legislative and/or regulatory initiatives
- The use of the Group Insurance Commission's purchasing power as a market force

Medicaid Payment Policy

Physicians and their representatives have presented the Finance Group with particular concerns about Medicaid payment rates and payment policy. Those concerns should be evaluated in the context of important commitments the Commonwealth has made through its Medicaid program and also in the context of vastly more difficult fiscal constraints than those that might have applied even a few short months ago.

The commitment of the Commonwealth to reduce the number of citizens without health insurance has been highly successful. The Commonwealth now ranks ninth among all states and third among comparable states with a large industrial base and significant urban populations for the percentages of the population without health insurance. [See figure 8]

Not only has the Commonwealth expanded eligibility and effectively enrolled eligible beneficiaries, but it has maintained one of the country's highest per beneficiary Medicaid payments to physicians (\$533), second only to New York (\$598) and 41.4% higher than the national average. [See figure 9]

Massachusetts Medicaid reimbursement strategy is deliberately weighted toward primary care. As a result, Massachusetts' average Medicaid fees for primary care visits are second only to the State of Washington and are 28.2% above the national average (\$39.23 vs. \$30.59). [See figure 10] Further, Massachusetts' Medicaid policy of favoring primary care services is consistent with the medical needs of the Medicaid population. Given a high percentage of female young adults and many children, Medicaid enrollees comprise a population uniquely suited to benefit from an emphasis on primary care (including ob/gyn and pediatric care). It is well documented that hospitalizations for a wide range of conditions can be reduced or prevented through appropriate primary care.³ Individuals with lower household incomes are more likely to be admitted for a preventable hospitalization.⁴ Thus, the Commonwealth's strategy to emphasize primary care for the Medicaid population is sound.

Recommendations:

The Finance Group believes the Commonwealth should do what it can to retain and attract physicians. They represent an extraordinary social, scientific and economic asset whose work benefits all citizens of Massachusetts. Nonetheless, the Finance Group does not find, at this time, that there is a precarious situation with respect to access to physician services generally. Even so, in an era of scarce resources, it is important, to paraphrase the physician's oath, that we should "at least do no harm."

Target Rate Increases to Further Medicaid Program Goals and System Stability.

Physicians have argued that Medicaid payment rates have fallen too low and that they should be increased at least to a level closer to that of Medicare and private payers. They have also argued that Medicaid rates have not been increased, even for inflation, for several years (with the exception of a modest increase in the last year), and that an inflation increase is necessary. Finally, they argue that, at a minimum, the Medicaid program should continue to pay Medicare-level co-insurance amounts for dually eligible Medicare enrollees rather than amounts based on the Medicaid fee schedule, as has been proposed.

In general, the Finance Group agrees that as payment rates under Medicare and managed care have failed to keep pace with increases in cost, Medicaid's inability to match cost increases compounds the "tax" on physicians to support these programs. However, because Medicaid is in the process of fully implementing a fee-setting methodology based on a "resource based relative value scale" (RBRVS) model (see attachment), a review of rates paid for individual codes is not a valid measure of the program's "fairness" in an inflationary environment. Put simply, the public policy decision embedded in the RBRVS methodology is to change certain payments for care over time

³ See, for example, *Improving Primary Care: Using Preventable Hospitalization as an Approach*. (Division of Health Care Finance and Policy: April 1995).

⁴ See for example Falik, Marilyn PhD, *, Needleman, Jack PhD, +, Wells, Barbara L. PhD, ++ and Korb, Jodi MA [S]. *Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers*. *Medical Care*. 39(6):551-561, June 2001; and *Improving Primary Care: Using Preventable Hospitalization as an Approach*. April 1995 Division of Health Care Finance and Policy.

by holding some constant while raising others. Under this type of model, rates for services that are deemed to have been underpaid in the past will be increased, while those for services that are deemed to have been overpaid will be decreased. According to the Division of Medical Assistance, additional resources have been added to physician payments in the aggregate in the last year and will be again for the current year.

The Finance Group supports the move toward full implementation of an RBRVS system, and encourages appropriate inflation adjustments once that system is set. As the new system is put into place and as additional funding is likely to be scarce, the Finance Group encourages the Division of Medical Assistance to apply increases in accordance with three priorities: emphasize services that are of particular importance to the Medicaid population (e.g., primary care, as opposed to specialty care); emphasize community-based physicians, as opposed to hospital-based physicians; and consider rewarding differentially those physicians whose practice has a significant percentage of Medicaid enrollees.

Maintain commitments to broad eligibility and primary care. The Commonwealth should maintain its commitments to broad eligibility and to primary care. At times of increasing demand, such as the current recession, this will be a politically and fiscally challenging task.

Exercise Caution on Dual Eligibles. In the Balanced Budget Act of 1997, Congress provided that, if they desire, state Medicaid programs could apply their own Medicaid fee schedules (as opposed to the Medicare fee schedule) when calculating the coinsurance payments they make on behalf of dual enrollees in Medicare and Medicaid. Massachusetts Medicaid currently uses the Medicare fee schedule to set co-insurance payments it makes on behalf of dually eligible enrollees, but has proposed “repricing” those coinsurance payments in accordance with the Medicaid fee schedule. For all other Medicaid enrollees with another primary insurer, Medicaid takes this approach. [See example, figure 11]

The Finance Group discussed at length the question whether Medicaid should pay physicians a coinsurance amount based on the full Medicare coinsurance or on the difference, if any, between the allowed Medicaid fee and the actual paid Medicare payment. The answer to this question depends on whether Medicaid, for dual eligibles, should be considered a “Medigap” policy or whether it is simply the insurer of last resort, as it is for all other enrollees. Put another way, should the physician receive a greater amount for a service provided to a Medicaid enrollee who happens to be eligible for Medicare than he or she would for the same service provided to a Medicaid enrollee who is not Medicare-eligible.

There is division of opinion in the Finance Group on this question, but most members of the Group believe that ideally, a physician should receive the full Medicare fee for treating a dually eligible patient, but that the federal government should pay 100% of the coinsurance amount paid by the Medicaid program that exceeds the Medicaid fee for that service. Given that the federal government currently only pays 50% of these payments,

some Finance Group members feel that Medicaid should pay an amount that will ensure the physician receives the same level of compensation for dually eligible patients as for Medicaid patients, particularly in a period of fiscal austerity.

Pursue Administrative Simplification. Physicians have noted that Medicaid uses outdated claims forms and administrative processes. Ongoing HIPAA compliance efforts will lead to vast improvements in this area over the next year. The Finance Group supports those efforts and joins previous recommendations of the Administrative Simplification Group in encouraging collaboration with physicians around simplification extending beyond HIPAA requirements.

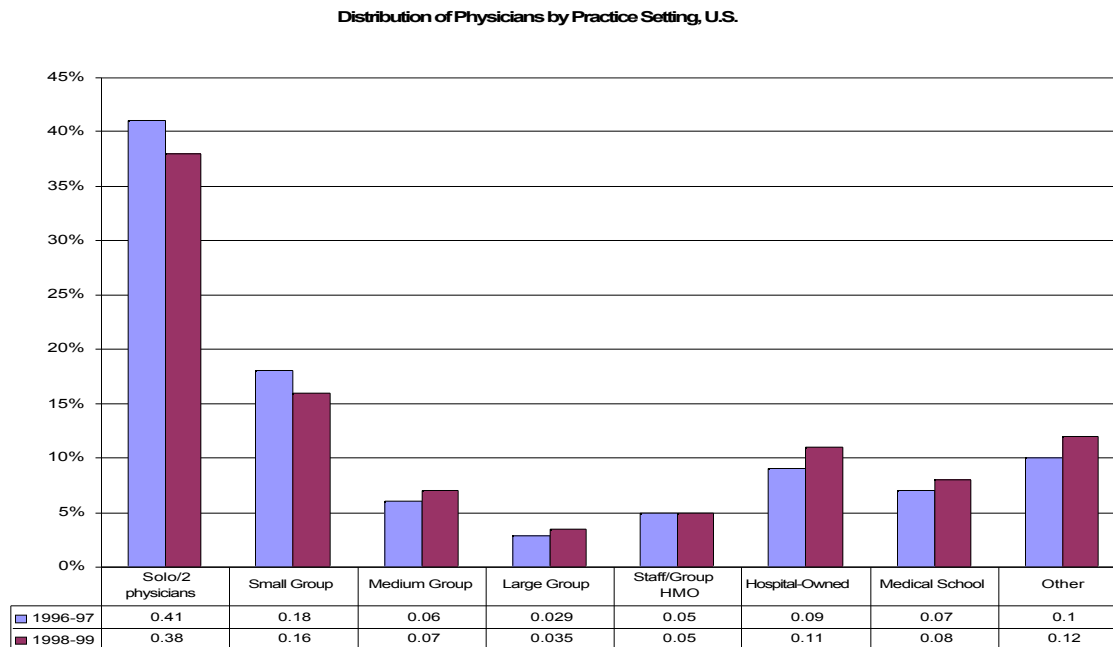
Explore Capitation Programs. Efforts to develop capitation models have been tried and largely abandoned in the 1990s. Only four plans still accept capitation from Medicaid. The Finance Group encourages development of new capitation demonstration projects, and emphasizes that rates must be sufficient to pay for care under those projects. Physicians have said that capitation failed in the past, in part, because data necessary to manage care was not available. Obviously, data will have to be provided to enable effective management of care.

Collect data and monitor conditions. As with other parts of the health care sector, data about physician practices, costs, practice patterns and relationships should be collected and monitored. This is a first step toward developing more informed health policy.

Sources

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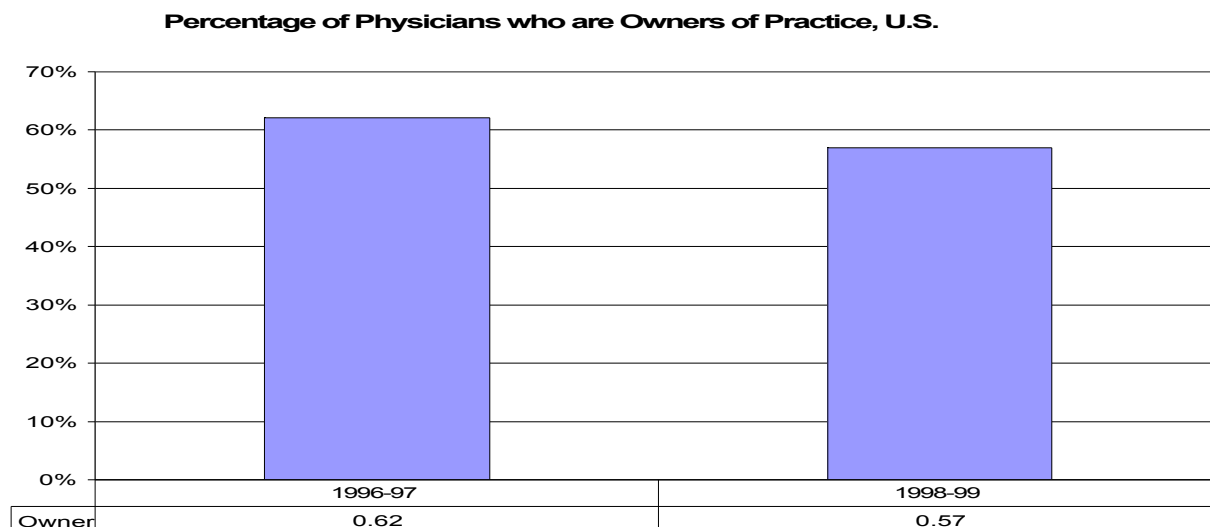
Figure 1



Source: Center for Studying Health System Change, 2001, HSC Community Tracking Study, Physician Survey, 1996-97 and 1998-99.

Physicians nationally were less likely to practice solo or in a small group in 1998-99 than in 1996-97, and more likely to practice in a larger group or hospital-owned practice.

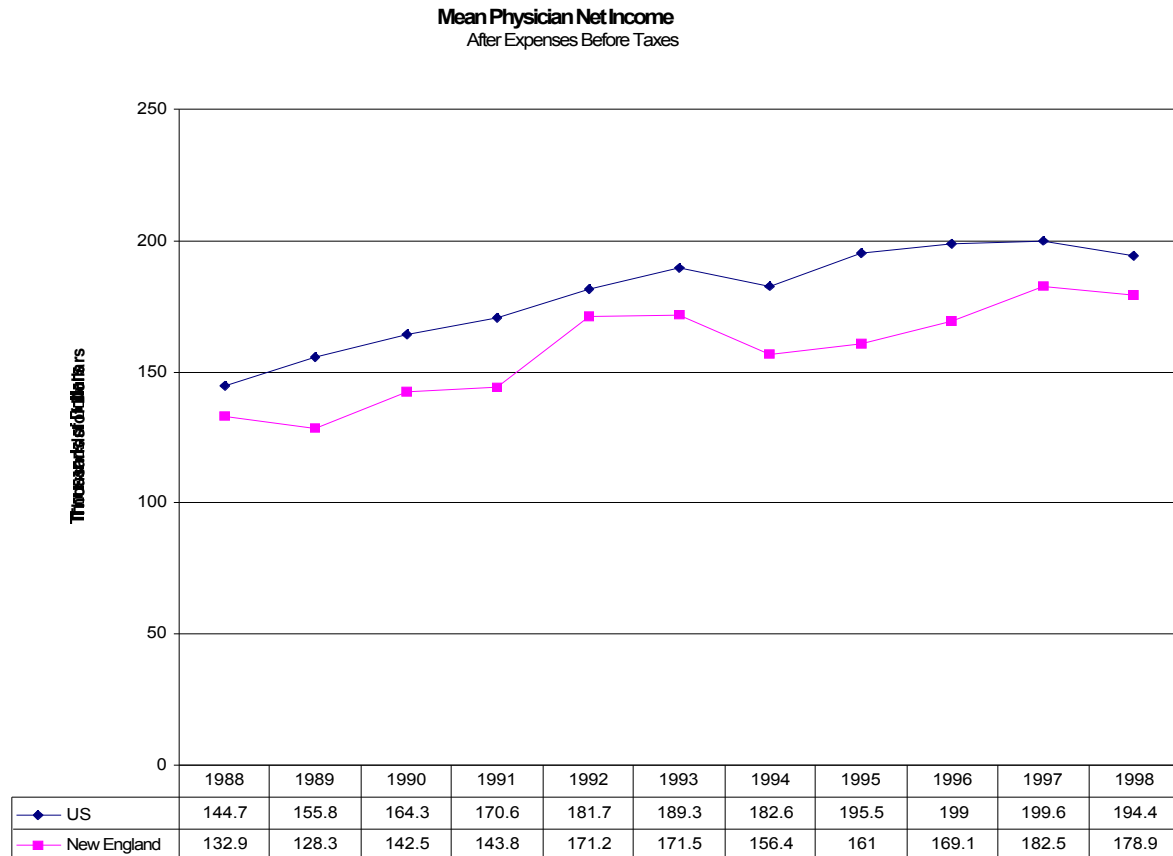
Figure 2



Source: Center for Studying Health System Change, 2001, HSC Community Tracking Study, Physician Survey, 1996-97 and 1998-99.

Physicians nationally were less likely to have ownership in their practice in 1998-99 than they were in 1996-97.

Figure 3

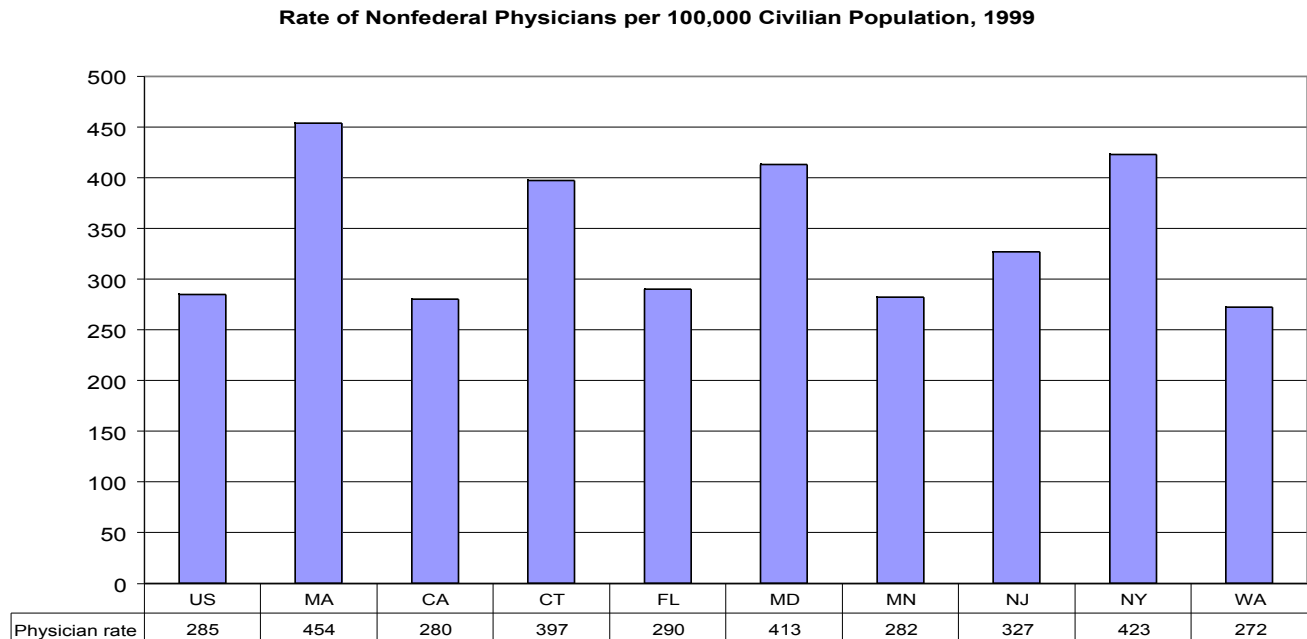


Source: AMA

Average physician income in the New England region has consistently been below the national average, possibly because of the region's large number of physicians splitting their time between practice, teaching and research, and large number of medical residents.

Figure 4: See attached Massachusetts maps of:
 Practicing Physicians per 100,000 Population, by County
 Primary Care Physicians by Zip Code
 Number of People per Primary Care Physician by Zip Code

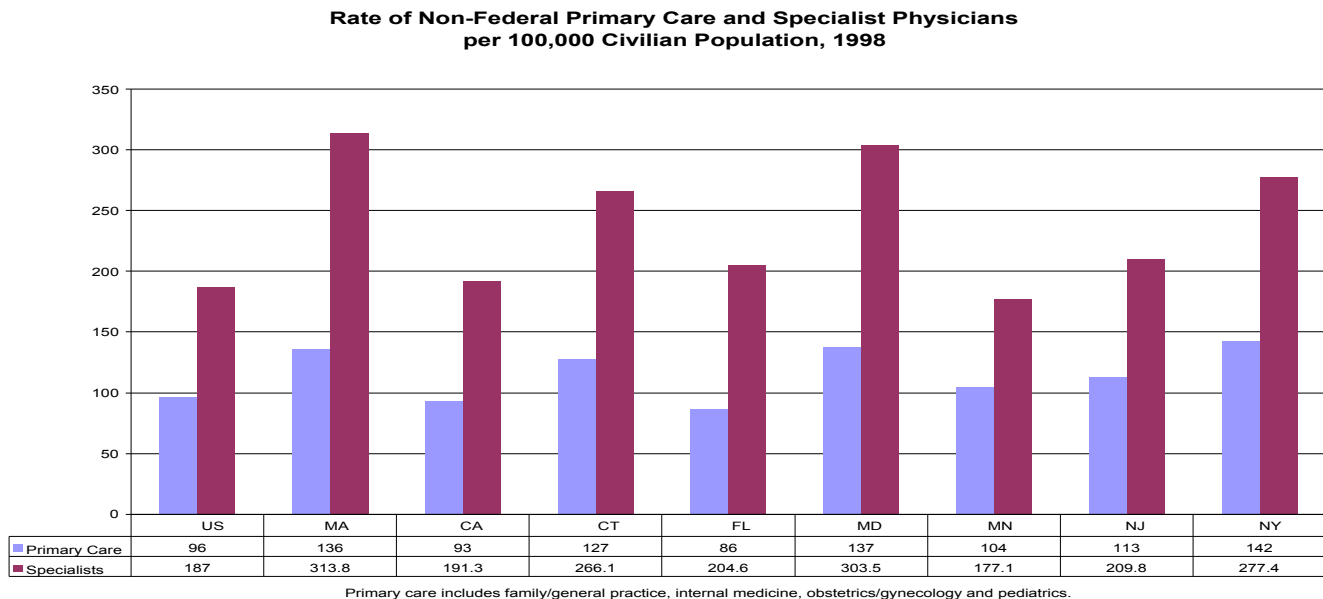
Figure 5



Source: AMA, taken from www.statehealthfacts.kff.org

Massachusetts has more physicians per capita than any other state in the nation.

Figure 6



Source: AMA

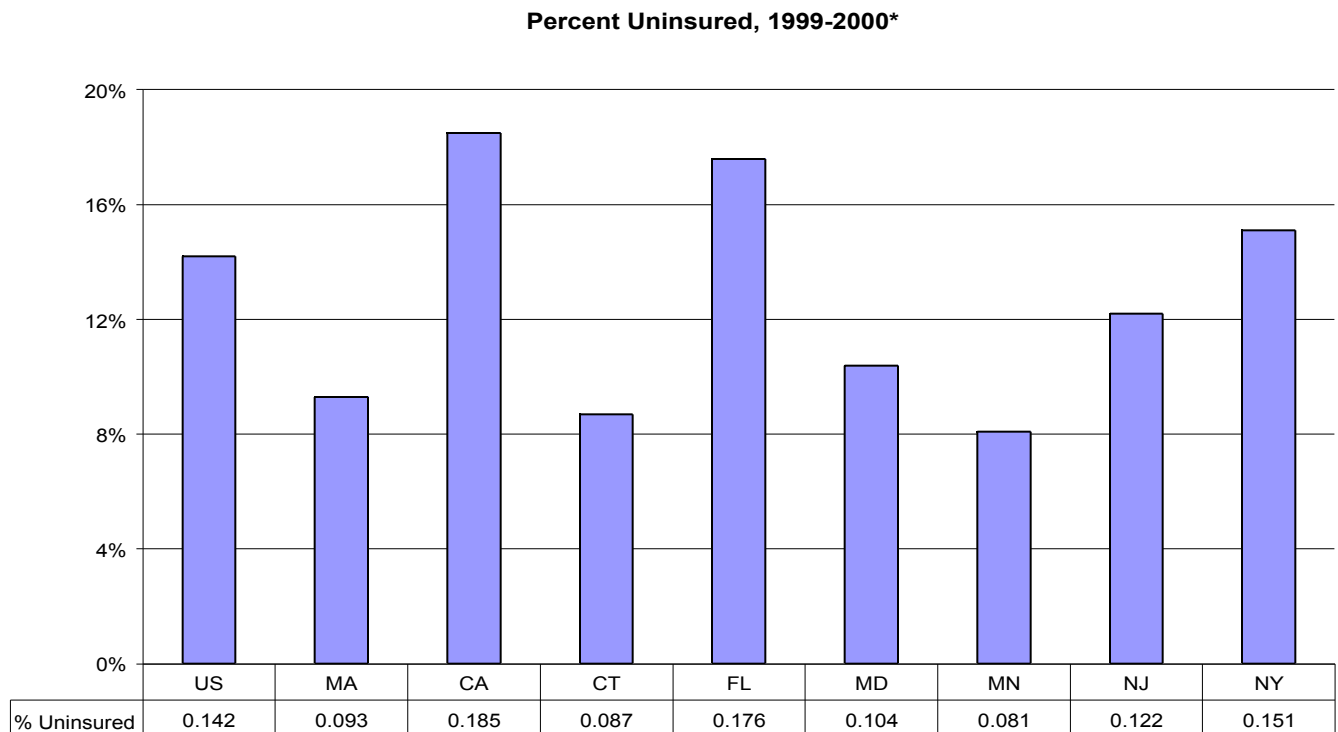
Massachusetts ranks 1st in number of specialists per capita and 3rd in number of primary care physicians per capita relative to all states.

Figure 7

Rate of Nonfederal Physicians in 1998		(Per 100,000 Population)							
State Rank	US	MA	CA	CT	FL	MD	MN	NJ	NY
Total		1	12	4	10	3	13	7	2
Patient Care		1	16	4	16	3	12	7	2
Medical Specialties		1	13	4	13	3	19	6	2
General/Family Practice		49	28	49	28	43	2	48	47
Internal Medicine		1	14	3	19	5	14	6	2
Pediatrics*		2	17	5	15	3	27	5	1
Surgical Specialties		4	21	3	12	1	27	7	1
General Surgery		2	33	4	27	5	31	8	1
Obstetrics & Gynecology		6	17	2	21	1	36	6	3
Ophthalmology		4	13	3	8	1	13	5	1
Orthopedic Surgery		3	19	2	23	6	14	16	8
Plastic Surgery		8	5	7	2	3	38	13	1
Anesthesiology		1	13	4	7	2	36	5	3
Psychiatry		1	11	3	25	5	29	7	2
Other Specialties		1	10	4	23	2	18	9	3
Rate per 100,000 population									
Total	276	443	278	388	283	405	276	319	414
Patient Care	221	342	215	306	215	314	221	259	332
Medical Specialties	84	162	80	139	80	140	75	120	154
General/Family Practice	29	18	29	18	29	24	49	19	20
Internal Medicine	45	97	42	81	39	79	42	65	90
Pediatrics*	79	143	75	123	79	134	63	123	145
Surgical Specialties	55	74	52	76	56	77	49	63	77
General Surgery	14.4	21.6	12.3	19.7	13.1	19.6	12.6	16.6	22.1
Obstetrics & Gynecology	28	35	27	41	26	42	21	35	39
Ophthalmology	6.5	8.8	6.4	9.1	7.5	9.9	6.4	7.8	9.9
Orthopedic Surgery	8.4	11.2	8.7	11.3	8.5	10.3	9	8.9	9.9
Plastic Surgery	2.2	2.5	2.8	2.7	3.1	3	1.5	2.3	3.2
Anesthesiology	12.2	19.4	12.5	15.3	13.2	16.9	9.4	14.7	16.7
Psychiatry	13.7	31.6	15.3	27	10.5	24.4	10.3	16.2	30.5
Other Specialties	68	125	69	102	62	109	63	74	106
* Per 100,000 population 17 years and younger									
Source: AMA									

Massachusetts ranks in the top 8 in terms of number of physicians per capita for all specialties listed, except General/Family Practice. Massachusetts's pattern of using physicians specializing in internal medicine, pediatrics or obstetrics and gynecology is consistent with practice patterns in other northeastern states.

Figure 8



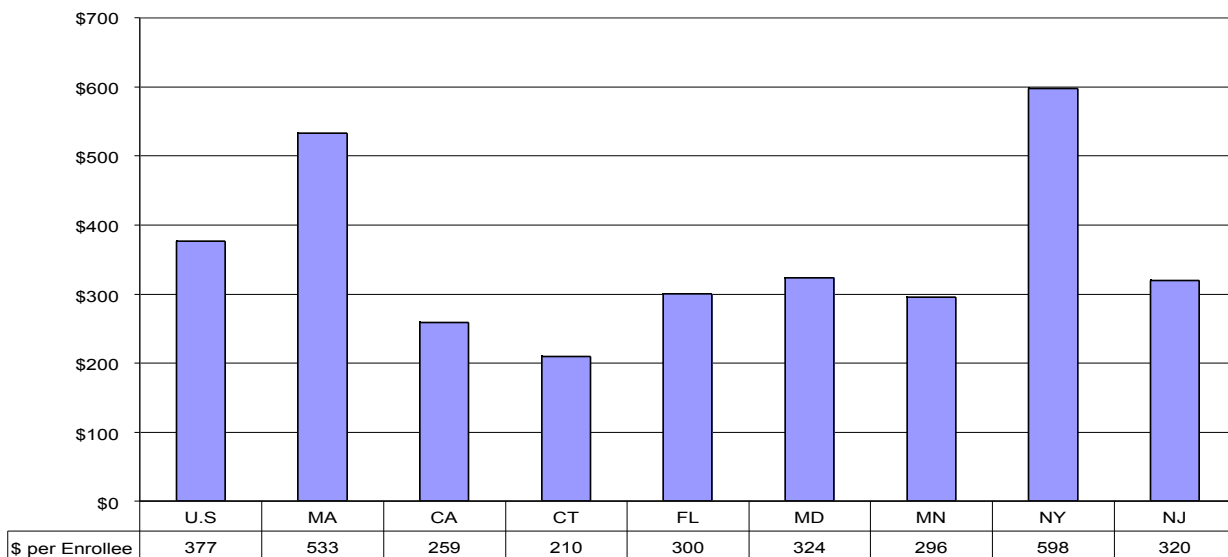
Source: US Census Bureau, Current Population Survey (CPS)

*These percentages are reported as two year averages of 1999 and 2000 CPS figures.

Massachusetts has the 3rd lowest percentage uninsured, relative to comparable states.

Figure 9

Medicaid Spending on Physicians Per Enrollee (1998 Estimates)

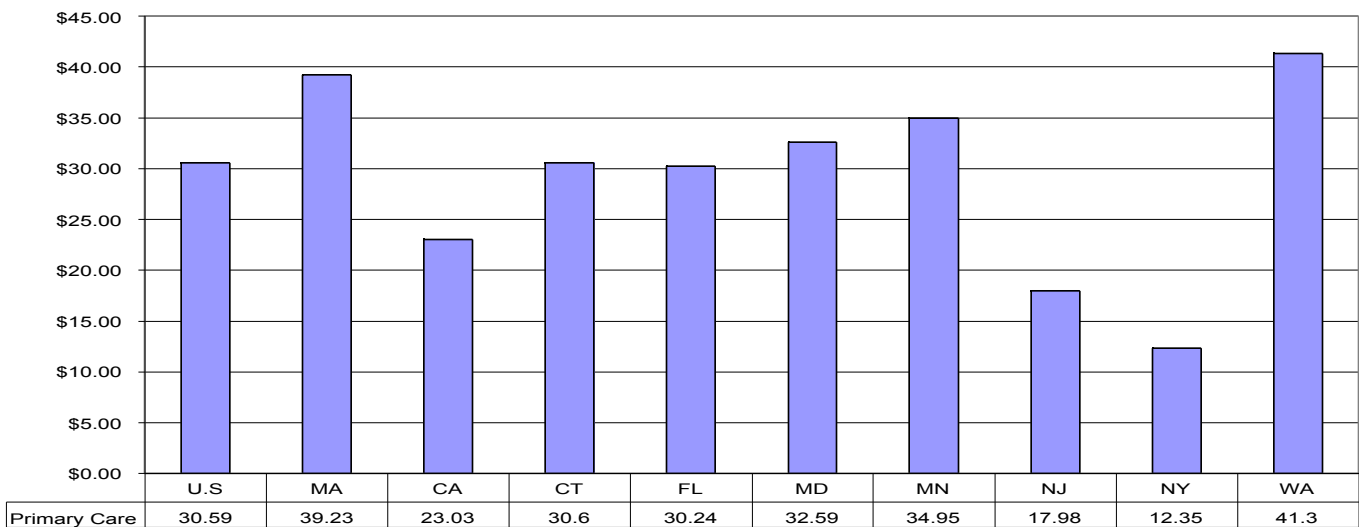


Source: HCFA, 1999

Massachusetts Medicaid spending on physician care per enrollee is considerably higher than the United States average and most comparable states.

Figure 10

1998 Average Medicaid Fees for Primary Care Visits



Source: Urban Institute, 1999

Average Medicaid fees for primary care visits are higher in Massachusetts than in any other state in the nation, except Washington.

Figure 11 Examples of the proposed Medicaid payment methodology for patients eligible for both Medicare and Medicaid (cross-over claims).

		(1)		(2)	
	Visit Type	Emergency Department Visit		Office Visit, Established Patient, Level 3	
	CPT Code	99283		99213	
		CURRENT	PROPOSED	CURRENT	PROPOSED
1	Medicare Fee 2000	68.09	68.09	52.28	52.28
2	Medicare Payment (.8 * L.1)	54.47	54.47	41.82	41.82
3	Patient Liability (.2 * L.2)	13.62	13.62	10.46	10.46
4	Medicaid Fee 2000	44.27	44.27	43.99	43.99
5	Medicaid Payment	13.62	0	10.46	2.17
6	Total Received by Physician (L.2 + L.5)	68.09	54.47	52.28	43.99

Currently, when a Medicare patient is also eligible for Medicaid, Medicare pays first, and then Medicaid pays the patient's liability (copayment, coinsurance, or deductible). That is, Medicaid acts as a Medigap plan for low income patients.

Federal law was recently changed to allow states to limit payments for patient liabilities after Medicare so that the total payment received by the provider from all sources is no more than what Medicaid would have paid if the patient had been solely a Medicaid enrollee.

There is currently a proposal in the legislature to implement this change in Massachusetts.

That is, Medicaid will pay as if the patient is a Medicaid enrollee, rather than paying like a Medigap Policy. This is the method currently used by the Medicaid program, for Medicaid patients Enrolled in private health insurance plans.

Note that, under either scenario, providers may not bill Medicaid recipients for the patient liability.

Attachment: Resource-Based Relative Value Scale

In 1992, Medicare significantly changed the way it pays for physicians' services. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on a resource-based relative value scale (RBRVS). In the RBRVS system, payments for services are determined by the resource costs needed to provide them. The cost of providing each service is divided into 3 components: physician work, practice expense, and professional liability insurance. Payments are calculated by multiplying the combined costs of a service by a conversion factor (a monetary amount that is determined by the Centers for Medicare and Medicaid [CMS]). Payments are also adjusted for geographical differences in resource costs.

The physician work component accounts, on average, for 54% of the total relative value for each service. The initial physician work relative values were based on the results of a Harvard University study. The factors used to determine physician work include: the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient. The physician work relative values are updated each year to account for changes in medical practice. Also, the legislation enacting the RBRVS requires the CMS to review the whole scale at least every 5 years.

The practice expense component of the RBRVS accounts for an average of 41% of the total relative value for each service. Practice expense relative values are currently based on a formula using average Medicare approved charges from 1991 (the year before the RBRVS was implemented) and the proportion of each specialty's revenues that is attributable to practice expenses. The professional liability cost component is derived from a similar formula. Legislation enacted in 1994 calls for CMS to replace the charge-based practice expense relative values with relative values based on the resource costs involved in each service.

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RBRVS Symposium 2001

Annual 2001 CPT Symposium & RBRVS Half day session

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Massachusetts Medicaid's Use of RBRVS

Massachusetts Medicaid implemented an RBRVS-based fee schedule in 1993. Like Medicare, Medicaid calculates the fee for each procedure by multiplying the combined costs of a service, called a Relative Value Unit (RVU), by a conversion factor. Medicare, however, uses the same conversion factor for all RVUs, while Medicaid uses different conversion factors for different families of procedure codes (CPTs). These conversion factors were originally derived from the Medicaid rates of payment in effect prior to the introduction of the RBRVS-based fee schedule.

From 1993 through 1999, Medicaid adjusted the various conversion factors, resulting in increases in some rates and decreases in others. The overall increase in physician payment rates during this period was minimal. In 2000, Medicaid implemented the first phase of a planned three year transition to a single conversion factor and, at the same time, increased total payments by 3.5%.

Medicaid has also implemented several policy initiatives that have resulted in enhanced payments to physicians; these payments are made in addition to the payment rate established through the RBRVS-based fee schedule. Since 1992, providers participating in the Primary Care Clinician (PCC) program, (Medicaid's internal PPO), have been paid an additional \$10 per primary care visit for case management. Second, providers receive an additional 13% or 37% for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Finally, providers can be paid an additional \$376 as part of an enhanced global obstetrical fee covering all physician prenatal and labor and delivery services.